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In the Supreme Court of the United States

OCTOBER TERM, 1982

CITY OF AKRON,

Petitioner,

v.

AKRON CENTER FOR REPRODUCTIVE HEALTH INC., et al.,

Respondents.

On Writ Of Certiorari To The United States Court Of Appeals For The Sixth Circuit

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BRIEF AMICUS CURIAE OF WOMANKIND, INC.

INTEREST OF THE AMICUS CURIAE

Womankind, Inc. is a charitable nonprofit community service in the Cleveland, Ohio area which has been providing women who have untimely pregnancies with counseling and assistance since 1975. Womankind affords three interrelated kinds of emergency pregnancy service: 1) crisis intervention counseling, 2) pre-natal infant and maternal health care services (Womankind operates the only medical clinic of this kind in the State of Ohio, with free medical care offered by a volunteer staff of licensed physicians, registered nurses, and technicians), and 3) long-term counseling, educational and supportive programs. Womankind support programs include psychiatric counseling, legal assistance, pre-natal medical care, clothing for mother and child, housing, transportation, furniture, financial counseling and assistance, and educational programs in nutrition, parenting, natural childbirth, breast-feeding, and other parent/child-oriented seminars. In addition, Womankind makes available professional and paraprofessional counselors specially trained in the sensitive areas of adoption and single parenthood through agreements with local accredited social services agencies. In 1981, seven staff members and 170 volunteers at two offices provided services to 7,183 clients. As an agency with the primary purpose of providing long term, positive assistance to persons in crisis due to an untimely pregnancy, Womankind is precisely the sort of agency about which pregnant women contemplating abortion are to be informed under Akron, Oh. Codified Ordinances §1870.06 (B)(7).

The trained professionals and paraprofessionals who staff Womankind have come in contact with thousands of women considering a choice between abortion and childbirth. Their experience gives them considerable insight

into the nature of the difficult dilemma these women face, and into the need these women have for material information about abortion and its alternatives in order freely to make a decision which is truly their own.

SUMMARY OF ARGUMENT

The Sixth Circuit struck down abortion informed consent provisions of the Akron, Ohio Ordinances because it held they "impinge[d] on the medical judgment of the attending physician [by requiring] the doctor to make certain disclosures in all cases, regardless of his professional judgment as to the desirability of doing so." *Akron Center for Reproductive Health* v. *City of Akron*, 651 F.2d 1198, 1207 (6th Cir. 1981). Similar grounds have been given by most of the other lower federal courts that have invalidated abortion related informed consent legislation.

This position is quite similar to the "physician paternalism" approach to informed consent requirements in medical malpractice litigation, an approach taken by 23 States and Puerto Rico. Under that approach, which is the original rule, the standard of disclosure is set by the practice of physicians in the locality.

The Sixth Circuit's position is at odds, however, with the newer "patient autonomy" approach taken by 10 States (including Ohio) and the District of Columbia, under which the standard of disclosure is not decided by physicians but imposed by the law. Under the "patient autonomy" approach, the physician is required to disclose whatever an average reasonable patient would consider material to the decision to undergo or refuse treatment, including the nature and purpose of the procedure, its risks, and available alternatives. Since 13 States take intermediate hybrid approaches, the position of the Sixth Circuit in asserting absolutely untrammeled discre-

tion in the physician about what to disclose is inconsistent with the malpractice informed consent disclosure standards of 23 States and the District of Columbia.

In effect, the Sixth Circuit and the other courts that have invalidated abortion related informed consent legislation have imposed upon the States what has been the view at one end of the spectrum of a controversy over informed consent standards of disclosure. At least in the context of abortion, they have frozen in constitutional concrete what has been hotly debated by commentators, courts and legislatures and hitherto open for state by state judgment and experimentation.

The Akron Ordinance applies the basic "patient autonomy" approach employed by Ohio to the particular circumstances of abortion. All of the categories in which it requires disclosure meet the basic standard that the information be material to the decision. It is disingenuous to argue, as some lower courts have, that information about the fetus is "medically irrelevant" to a woman's decision, since the essence of the procedure is elimination of the fetus. Withholding such information, ostensibly to spare pregnant women's sensitivities, makes a paternalistic mockery of the "freedom of choice" right, and skews the basis for her decision.

Although the laws of some "patient autonomy" jurisdictions, unlike the Akron Ordinance, have a "therapeutic exception" to the duty of disclosure when the physician thinks disclosure will harm the patient, others, including Ohio, do not. Furthermore, scholarly commentators have attacked the "therapeutic exception" as destructive of the disclosure rule, more harmful than good in the long run, and unnecessary for competent patients. Thus, the Akron Ordinance is well within the bounds of the "patient autonomy" approach to informed consent.

Legislatures have particularly appropriate grounds for applying a "patient autonomy" rather than a "physician paternalism" approach in the area of abortion. Most abortions are not performed in the context of the traditional physician-patient relationship. Rather, they take place at abortion clinics in many of which the patient does not even meet a physician until she is on the operating table. "Counseling," when it exists, is done by nonmedical personnel, sometimes only in groups. This atmosphere does not allow for the individualized physician judgment about disclosure presupposed by the benevolent assumptions underlying the "physician paternalism" approach. Furthermore, information publicized as a result of the 1978 *Chicago Sun-Times* undercover investigation of a number of high-volume abortion clinics shows that "counseling" is sometimes designed to "sell" abortions rather than to foster the best interests of the patient. It documents that a significant number of abortion clinic doctors pay scant attention to patient care in their rush to perform as many abortions as possible to increase their personal profits.

Both the socioeconomic context in which abortion is frequently performed and the special "freedom of choice" nature of the abortion right make especially defensible a legislative choice of the "patient autonomy" over the "physician paternalism" approach to abortion informed consent. Whatever rules this Court may announce to govern informed consent statutes, the Constitution should not be interpreted to rob the States of the flexibility to prefer a "patient autonomy" approach to abortion.

ARGUMENT

I.

CONSIDERATION OF THE CONTROVERSY BETWEEN THE "PHYSICIAN PATERNALISM" AND THE "PATIENT AUTONOMY" APPROACHES TO GENERAL INFORMED CONSENT DOCTRINE IS CRITICAL IN DECIDING THE CONSTITUTIONALITY OF THE "INFORMED CONSENT" PROVISIONS OF THE AKRON ORDINANCE.

The Sixth Circuit Court of Appeals invalidated every provision of the Akron, Ohio Codified Ordinances requiring disclosure of information to a woman before she consents to an abortion. It did so because that court deemed it to be unconstitutional for any legislature to "impinge on the medical judgment of the attending physician [by requiring] the doctor to make certain disclosures in all cases, regardless of his own professional judgment as to the desirability of doing so." *Akron*, 651 F.2d at 1207. Many other courts that have held abortion related informed consent statutes unconstitutional have also grounded such rulings in the proposition that no legislature may interfere with the untrammeled discretion of a physician to withhold information from patients prior to an abortion. *See, e.g., Planned Parenthood Association of Kansas City, Mo.* v. *Ashcroft*, 655 F.2d 848, 867 (8th Cir. 1981); *Charles* v. *Carey*, 627 F.2d 772, 784 (7th Cir. 1980); *Leigh* v. *Olson*, 497 F.Supp. 1340, 1345 (D.N.D. 1980).

Although no lower court dealing with abortion related informed consent legislation has taken note of it, courts and scholarly commentators are currently engaged in a controversy over what ought to be the standard of disclosure for informed consent to medical treatment of any kind. This debate, which is being conducted without specific reference to abortion, concerns two competing perspectives.

One perspective, which emphasizes physician discretion and judgment, may be called the "physician paternalism" approach. Its proponents say the standard of disclosure ought to be that practiced by physicians in the locality. This approach, like that taken by the Sixth Circuit in this case, assumes that doctors generally know what is best for their patients, and gives doctors, as a group, great leeway to circumscribe the breadth and scope of the information to be disclosed to or withheld from the patient.

The other perspective, which emphasizes patient knowledge and decision, may be called the "patient autonomy" approach. Its proponents say the standard of disclosure ought to be what an average, reasonable patient would consider material to the decision, regardless of what physician practice may be. This approach assumes that competent adults should be enabled to determine for themselves what is done with their bodies, and places the premium on patient freedom of choice.

Ohio case law on informed consent to medical treatment in general has adopted the "patient autonomy" approach. *Congrove* v. *Holmes*, 37 Ohio Misc. 95, 308 N.E.2d 765, 771 (Comm. Pleas 1973). See Section III of this brief. The City Council of Akron chose to apply this approach to abortion by adopting an ordinance specifying particular required disclosures. See Section IV of this brief. The municipal legislature chose not to defer to the abortion-performing physician's view of what is best and allow him or her to control the flow of information to the patient, as does the "physician paternalism" approach; rather, it proceeded on the assumption that abortion is an especially personal decision, to be made by the woman herself, and sought to assure her of access to the information material to that decision, thus employing the rationale behind the "patient autonomy" approach.

Without any discussion of the arguments which have been advanced for and against each approach, or of the

relation of constitutional provisions to those arguments, the Sixth Circuit and other courts, in striking abortion related informed consent laws, have in effect held that in the context of abortion the Constitution imposes on the States the "physician paternalism" option and forbids to them the "patient autonomy" option.

In the belief that no final ruling on the application of the Constitution to informed consent requirements for abortion should be made without at least some consideration of the nature of informed consent requirements for medical treatment in general, your *amicus* offers this brief for the limited purpose of discussing the debate over the two competing approaches to informed consent disclosure standards and the relevance of that debate to the validity of legislative judgments about what standard best achieves effective freedom of choice for women deciding whether to undergo abortion.

This brief addresses what should be a central issue in this case: whether, in light of the considerable controversy over the respective wisdom of the "physician paternalism" and "patient autonomy" approaches, the Court should adopt a rule that constitutionally freezes the "physician paternalism" approach as the only allowable model for abortion related informed consent legislation, or whether, "when an issue involves policy choices as sensitive as those implicated [here] . . . , the appropriate forum for their resolution in a democracy is the legislature." *Maher* v. *Roe*, 432 U.S. 464, 479 (1977).

II.

MEDICAL TREATMENT REQUIRES THE CONSENT OF THE PATIENT, AND THE UNIVERSAL MODERN RULE IS THAT THE CONSENT MUST BE INFORMED.

Under Anglo-American law, it is axiomatic that a physician must first obtain the patient's consent before undertaking any non-emergency treatment. As Justice Cardozo

stated in *Schloendorff* v. *Society of New York Hospital*, 211 N.Y. 125, 129-130, 105 N.E. 92, 93 (1914):

> Every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent, commits an assault, for which he is liable in damages.

As the consent doctrine evolved, it became necessary under the law for the physician not only to obtain permission to proceed, but also to make a reasonable disclosure to the patient of the nature and probable consequences of the proposed treatment. *See Salgo* v. *Stanford University Bd. of Trustees*, 154 Cal. App.2d 560, 317 P.2d 170 (Ct. App. 1957) (landmark case introducing the principle). "Numerous courts throughout the 1960's looked beyond the fact of the patient's consent to question the quality of the physician's disclosure underlying the consent." A Rosoff, *Informed Consent* 4 (1981). Some version of informed consent requirement is now in effect in all but two of the United States. *See* Table of Current Positions on the Approach to Informed Consent by State, this brief at 11; App. 6n.42 (S.C.); App. 6n.43 (S.D.).

III.

THE OLDER "PHYSICIAN PATERNALISM" APPROACH HAS BEEN REPLACED BY THE NEWER "PATIENT AUTONOMY" APPROACH IN OHIO AND A SUBSTANTIAL NUMBER OF OTHER STATES.

When informed consent doctrine first came to be applied in the late 1950s and early 1960s, it was initially analyzed in the manner of traditional medical malpractice tort negligence. Like the duty of care by which deviations amounting to negligence are measured, the duty of disclosure by which deviations amounting to denial of informed consent were to be measured was set as "those disclosures which a reasonable medical practitioner would make under the same

or similar circumstances." *Natanson* v. *Kline*, 186 Kan. 393, 409-10, 350 P.2d 1093, 1106 (1960). This approach came to mean that a physician need only disclose those facts which the average, reasonable practitioner, of the same speciality and geographic location, would have revealed under similar circumstances. Victor, *Informed Consent*, 1981 Medical Trial Tech. 138, 146. *See, e.g., Woolley* v. *Henderson*, 418 A.2d 1123, 1128-32 (Me. 1980).

Courts first began to move away from this approach in dealing with elective surgery—a category into which most abortions fall. For example, in *Scott* v. *Wilson*, 396 S.W. 2d 532 (Tex. Civ. App. 1965) *aff'd sub. nom Wilson* v. *Scott*, 412 S.W.2d 299 (Tex. 1967), the court held that when a patient is considering an elective operation, a physician has the duty to make a full disclosure of the nature of the operation, the processes contemplated, the dangers of the operation and possible alternatives to the treatment.

The full introduction of the "patient autonomy" approach into case law came in *Canterbury* v. *Spence*, 464 F.2d 772 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972), which remains the leading case. The D.C. Circuit concluded that "[r]espect for the patient's right of self-determination on particular therapy demands a standard set by law for physicians rather than one which physicians may or may not impose upon themselves." *Id.* at 780. It based its decision on the premise that "it is the prerogative of the patient, not the physician, to determine for himself the direction in which his interests lie," and that the duty to disclose information important for that determination is not "dependent upon the existence and nonperformance of a relevant professional tradition." *Id.* at 777, 779.

Instead of usual professional practice, therefore, the court concluded that

> the patient's right of self-decision shapes the boundaries of the duty to reveal. That right can be effective-

> ly exercised only if the patient possesses enough information to enable an intelligent choice. The scope of the physician's communications to the patient, then, must be measured by the patient's need, and that need is the information material to the decision. Thus the test for determining whether a particular peril must be divulged is its materiality to the patient's decision.

Id. at 782-83.

The *Canterbury* v. *Spence* "patient autonomy" approach came to be followed by a substantial minority of jurisdictions. Adopting the position, a Maryland court summarized the trend:

> In recent years . . . an ever-expanding number of courts have declined to apply a professional standard of care in informed consent cases, employing instead a general or lay standard of reasonableness set by law and independent of medical custom. These decisions recognize that protection of the patient's fundamental right of physical self-determination—the very cornerstone of the informed consent doctrine—mandates that the scope of a physician's duty to disclose . . . be governed by the patient's informational needs. Thus, the appropriate test is not what the physician in the exercise of his medical judgment thinks a patient should know before acquiescing in a proposed course of treatment; rather, the focus is on what data the patient requires in order to make an intelligent decision.

Sard v. *Hardy*, 281 Md. 432, 442, 379 A.2d 1014, 1021 (Ct. App. 1977). *See also* Victor, *supra* p. 9, at 148; Seidelson, *Medical Malpractice: Informed Consent Cases in "Full Disclosure" Jurisdictions*, 14 Duq. L. Rev. 309, 312 (1976). The accompanying table summarizes the 1982 position on standards of disclosure of D.C., Puerto Rico, and the 50 states. 24, or half of the jurisdictions with positions, adopt an approach differing from the pure "physician paternalism" model which the Sixth Circuit held to be the only approach the Constitution accepts when applied to abortion.

TABLE OF CURRENT POSITIONS ON THE APPROACH TO INFORMED CONSENT BY STATE*

State	No Law	Patient Autonomy	Physician Paternalism	Hybrid
Alabama[1]			X	
Alaska[2]				X
Arizona[3]			X	
Arkansas[4]			X	
California[5]				X
Colorado[6]			X	
Connecticut[7]	X			
Delaware[8]			X	
District of Columbia[9]		X		
Florida[10]				X
Georgia[11]			X	
Hawaii[12]			X	
Idaho[13]				X
Illinois[14]			X	
Indiana[15]				X
Iowa[16]				X
Kansas[17]			X	
Kentucky[18]				X
Louisiana[19]		X		
Maine[20]			X	
Maryland[21]		X		
Massachusetts[22]				X
Michigan[23]			X	
Minnesota[24]		X		
Mississippi[25]			X	
Missouri[26]			X	
Montana[27]			X	
Nebraska[28]			X	
Nevada[29]				X
New Hampshire[30]			X	
New Jersey[31]			X	
New Mexico[32]		X		
New York[33]			X	
North Carolina[34]				X
North Dakota[35]			X	
Ohio[36]		X		
Oklahoma[37]				X
Oregon[38]		X		
Pennsylvania[39]		X		
Puerto Rico[40]			X	
Rhode Island[41]		X		
South Carolina[42]	X			
South Dakota[43]	X			
Tennessee[44]			X	
Texas[45]				X
Utah[46]			X	
Vermont[47]				X
Virginia[48]			X	
Washington[49]		X		
West Virginia[50]	X			
Wisconsin[51]		X		
Wyoming[52]			X	
TOTAL	4	11	24	13

* The sources for this summary are given state by state in the Appendix.

The only Ohio court to face the issue squarely has adopted the patient autonomy rule, relying on *Canterbury*.* "The duty to disclose serious risks should not be based upon the doctor's practices but upon the patient's need for full disclosure of serious risks and the feasibility of alternatives in order for the patient to make an intelligent and informed choice." *Congrove* v. *Holmes*, 308 N.E.2d at 771 (Comm. Pleas 1973). The Ohio informed consent statute applicable to medical treatment generally provides that in order for written consent to be presumed valid, it must set "forth in general terms the nature and purpose of the procedure or procedures, and what the procedures are expected to accomplish, together with the reasonably known risks, and, except in emergency situations, [set] forth the name of the physicians who shall perform the intended surgical procedures." Oh. Rev. Code Ann. § 2317.54 (A) (Baldwin Supp. 1981).

The newer "patient autonomy" approach, therefore, is seen to be an approach accepted and advocated by a substantial minority of States for reasons closely related to the essential basis of informed consent doctrine. This understanding counsels against pre-empting legislative choice through the establishment of a constitutional rule compelling "physician paternalism."

IV.

THE AKRON ORDINANCE APPLIES THE "PATIENT AUTONOMY" APPROACH TO ABORTION.

The Akron Ordinance provides for disclosure concerning the woman's pregnancy, abortion risks, alternatives to

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* In *Bruni* v. *Tatsumi*, 46 Oh. St. 2d 127, 136, 346 N.E.2d 673, 680 (1976), the Ohio Supreme Court, in dealing with other aspects of informed consent doctrine, which it described as "not particularly well-developed in Ohio cases," relied primarily upon *Canterbury*. However, the court did not deal with the issue of the "patient autonomy" vs. the "physician paternalism" standards of disclosure.

abortion, and the fetus. It was logical for the municipal legislature to consider all of these categories to be material to the decision whether or not to undergo the procedure, and since materiality to the decision is the standard for disclosure employed by the courts that have adopted the "patient autonomy" approach, disclosure with regard to these categories lies fully within the bounds of informed consent doctrine.

> Over the 20-odd years since the term *informed consent* came into usage in the medicolegal context, courts have been developing, on a case-by-case basis, a list of items requiring disclosure. Stated in simple, generic terms, the list includes:
>
> * diagnosis (i.e., the patient's condition or problem)
> * nature and purpose of the proposed treatment
> * risks and consequences of the proposed treatment
> * probability that the proposed treatment will be successful
> * feasible treatment alternatives
> * prognosis if the proposed treatment is not given.

Rosoff, *supra* p. 8, at 41 (emphasis in original).

The specific requirements of the Akron Ordinance fit within these categories. The disclosure provided by §§1870.06(B)(1) and (2) concerning the patient's pregnant condition and the stage of her pregnancy is of diagnostic information. The disclosure provided by §1870.06(B)(7) concerning the agencies and services available to assist her during pregnancy and after childbirth if she does not choose abortion is of information concerning treatment alternatives. The disclosure provided by §1870.06(B)(5) concerning the possible complications of abortion is of information in a classic informed consent category: risks of the proposed treatment. So long as the "patient autonomy" approach is accepted as a constitutionally available alternative to the "physician paternalism" approach for abortion related informed consent legislation, objection can hardly be made to requiring specific disclosures in these categories.

It has been suggested, however, that disclosure concerning the existence and characteristics of the fetus, such as that provided by Akron Oh. Codified Ordinances §§1870.06 (B)(3) and (4), "is not directly material to any medically relevant fact, and thus does not serve the concern for providing adequate medical information that lies at the heart of the informed consent requirement." *Planned Parenthood League of Massachusetts* v. *Bellotti*, 641 F.2d 1006, 1021 (1st Cir. 1981). This perception misconceives both the nature of the standard of disclosure in informed consent doctrine—at least under the "patient autonomy" approach—and the meaning of "medically relevant" in the context of abortion as that concept has been delineated by this Court.

"[T]he very basis of the informed consent theory [is] the patient's right to be the final judge to do with his body as he wills." *Wilkinson* v. *Vesey*, 110 R.I. 606, 625, 295 A.2d 676, 688 (1972). Central to this position is the view that the "decision about what is or is not relevant information upon which a patient can base an informed consent is a human judgment, not a determination requiring medical expertise." Note, *Restructuring Informed Consent: Legal Therapy for the Doctor-Patient Relationship*, 79 Yale L.J. 1533 (1970). *Accord, Wilkinson*, 110 R.I. at 625, 295 A.2d at 688. In the "patient autonomy" view, therefore, the nature of the information deemed material to the patient's decision is not inherently limited to a description only of physical health risks associated with the procedure; rather, the question of materiality is, as a Washington court phrased it, "Would the patient as a human being consider this item in choosing his or her course of treatment?" *Miller* v. *Kennedy*, 11 Wash. App. 272, 282-283, 522 P.2d 852, 860 (Ct. App. 1974), *aff'd* 85 Wash.2d 151, 530 P.2d 334 (1975).

Thus, Ohio's informed consent statute applicable to all forms of medical treatment provides for information not

only about the "reasonably known risks," but also about "the nature and purpose of the procedure." Oh. Rev. Code Ann. § 2317.54 (A) (Baldwin Supp. 1981). The Akron Ordinance applies this perspective specifically to abortion. It provides for information about the existence and development of the fetus whom it is the nature and purpose of the procedure to eliminate.

It is simply disingenuous to argue that information about the fetus is irrelevant to a choice about abortion, and that the only things "the patient as a human being [would] consider" in making a reflected choice whether to undergo it are physical health risks. As this Court noted in *Roe* v. *Wade*, 410 U.S. 113, 116 (1973), "One's philosophy, one's experiences, one's exposure to the raw edges of human existence, . . . one's attitudes toward life and family and their values, and the moral standards one establishes and seeks to observe, are all likely to influence and to color one's thinking and conclusions about abortion." That network of values revolves around the attitude one takes toward the fetus's status and prospects as weighed together with the needs and plans of the pregnant woman and perhaps her family. If, as Laurence Tribe has suggested, "*Roe* v. *Wade* represents less a decision in favor of abortion than a decision in favor of leaving the matter, however it might come out in particular cases, to women . . . ," L. Tribe, American Constitutional Law 933 (1978), then it cannot properly be said that the whole tangle of ethical and human issues inherently associated with abortion are to be deemed irrelevant to women's decisionmaking. Those issues are inextricably bound up with the existence and nature of the fetus.

The applicability of the "patient autonomy" informed consent rationale is not diminished because information about the fetus has no precise analogue in information required to be disclosed about other medical procedures. "The simple answer to the argument that similar require-

ments are not imposed for other medical procedures is that such procedures do not involve the termination of a potential human life." *Maher* v. *Roe,* 432 U.S. at 480. The essential point is that the rationale for the disclosure of fetal information is the same as that for the disclosure of information associated with medical treatment other than abortion: in the "patient autonomy" view, disclosure should be made of "what the patient would consider important to [her] decision." *Canterbury* v. *Spence,* 464 F. 2d at 783. It is logical for the legislature to conclude that information about the fetus meets that criterion.

There is another reason why the First Circuit was wrong to consider fetal information "medically irrelevant." Its notion of the scope of medical relevance is mechanistically narrow in a manner at odds with this Court's delineation of that concept in the context of abortion. "[M]edical judgment," the Court held, "may be exercised in the light of all factors—physical, emotional, psychological, familial, and the woman's age—relevant to the well-being of the patient. All these factors may relate to health." *Doe* v. *Bolton,* 410 U.S. 179, 192 (1973). This sense of the medically relevant is certainly broader than merely physical complications; it argues against the exclusion of fetal information from the realm of the "medical."

In sum, abortion related informed consent legislation like the Akron Ordinance is rooted in the philosophy that underlies the "patient autonomy" approach to informed consent used by a respectable minority of the States: "The patient has the right to chart [her] own destiny, and the doctor must supply the patient with the material facts the patient will need in order to intelligently chart that destiny with dignity." *Miller* v. *Kennedy,* 11 Wash. App. at 282, 522 P.2d at 860. The requirement to disclose information about the woman's pregnancy, abortion risks,

alternatives to abortion, and the fetus is medically relevant and fits appropriately with "patient autonomy" informed consent doctrine.

V.

FROM A "PATIENT AUTONOMY" PERSPECTIVE, THERE IS AMPLE PRECEDENT AND REASON FOR PROVIDING NO "THERAPEUTIC EXCEPTION" IN THE AKRON ORDINANCE.

The Akron Ordinance requires disclosure in all non-emergency instances. It thus parts company with some "patient autonomy" jurisdictions which hold that a physician has a limited privilege not to disclose information to a patient for "therapeutic" reasons, an exception to the general duty of disclosure which is not recognized by other states and which has been subjected to considerable scholarly attack. The exception, where it is recognized, is meant to deal with occasions when disclosure would risk making a patient "so ill or emotionally distraught . . . as to foreclose a rational decision, or complicate or hinder the treatment, or perhaps even pose psychological damage to the patient." *Canterbury* v. *Spence*, 464 F.2d at 785. The Canterbury court itself warned, however, that the therapeutic exception

> must be carefully circumscribed . . . for otherwise it might devour the disclosure rule itself. The privilege does not accept the paternalistic notion that the physician may remain silent simply because divulgence might prompt the patient to forego therapy the physician feels the patient really needs. That attitude presumes instability or perversity even for the normal patient, and runs counter to the foundation principle that the patient should and ordinarily can make the choice for himself.

Id.

The court concluded that the privilege to withhold disclosure should operate only when the physician reasonably

forsees that the patient's reaction will be "menacing." *Id.** Indeed, a number of states which employ or have elements of the "patient autonomy" approach have failed to recognize a "therapeutic exception." Notably, Ohio is among them. (The others are Florida, Kentucky, Nevada and Pennsylvania.) Meisel & Kabnick, *Informed Consent to Medical Treatment: An Analysis of Recent Legislation*, 41 U. Pitt. L. Rev. 407, 457 (1980); *Dunham* v. *Wright*, 423 F.2d 940, 944-45 (3rd Cir. 1970) (construing Pennsylvania law).

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* The heart of the argument given by "patient autonomy" jurisdictions for rejecting "physician paternalism" is that "[u]nlimited discretion in the physician is irreconcilable with the basic right of the patient to make the ultimate informed decision regarding the course of treatment to which he knowledgeably consents to be subjected." *Cobbs* v. *Grant*, 8 Cal.3d 229, 243, 502 P.2d 1, 10, 104 Cal. Rptr. 505, 514 (1972). It is not surprising, therefore, that even in States allowing the therapeutic exception a number of courts have openly recognized the dangers it poses and endeavored to construe it extremely narrowly. In *Kinikin* v. *Heupel*, 305 N.W.2d 589 (Minn. 1981), for example, the Minnesota Supreme Court declared that a doctor cannot invoke the therapeutic privilege merely to avoid aggravating a patient's emotional trauma when sound medical practice demands that risks be disclosed. The court asserted that the greater a patient's fears, no matter how peculiar or unfounded they may be, the greater is the physician's duty to discuss the risks of treatment. "In all situations, it is to the advantage of both the patient and his physician that the latter not presume too much upon the apparent experience or expertise of the former." *Id.* at 595. Similarly, in denying a claim that information relating to ulcer surgery was properly withheld under the therapeutic privilege, the California Supreme Court noted that the role of the doctor, as an expert, is only to know and reveal the risks inherent in medical procedures. "The weighing of these risks against the individual subjective fears and hopes of the patient is not an expert skill. Such evaluation and decision is a nonmedical judgment reserved to the patient alone." *Cobbs* v. *Grant*, 8 Cal.3d at 243, 502 P.2d at 10, 104 Cal. Rptr. at 514.

Three grounds are given in the scholarly commentary for rejection of the therapeutic exception, grounds that provide a supportable basis for the decision of the Akron City Council not to include such an exception in the Akron Ordinance: 1) as *Canterbury* concedes, the exception poses grave danger of vitiating the rule; 2) the harm that may come from disclosures the therapeutic exception is intended to prevent is minimal and in any case less than the harm likely to come from preventing these disclosures, and 3) the sort of disclosures most likely to be harmful are adequately prevented by the incompetency exception without need for a therapeutic exception.*

There is strong academic criticism of the therapeutic exception. Professor Alan Meisel, who teaches psychiatry as well as law, believes "(t)he danger that the therapeutic privilege poses to self-determination in medical decisionmaking is so great that we should seriously consider its abolition." Meisel, *The "Exceptions" to the Informed Consent Doctrine,* 1979 Wisc. L. Rev. 413, 467. Meisel warns that even when the therapeutic exception is narrowly circumscribed, the manner in which it is applied can still undermine patient autonomy. The power the law gives to physicians to determine how and whether the exception applies creates "an incentive for the physician to invoke an exception in order to provide treatment to a patient whom he believes would refuse it." *Id.* at 476. Coupled with "the physician's authority and control over

* "A patient whose emotional state is so fragile that risk-disclosure might seriously harm him or prevent him from participating rationally in decisonmaking might be considered incompetent. . . . If there is any room at all for the [therapeutic] privilege, it must be framed in terms of interference with the patient's decisionmaking capabilities, in which case the incompetency exception might serve as well." Meisel, *The "Exceptions" to the Informed Consent Doctrine,* 1979 Wisc. L. Rev. 413, 467.

relevant information, and traditionally deferential patient attitudes towards physicians," this power to invoke the therapeutic exception successfully tips the balance between individualism and the health profession in favor of physician paternalism. *Id.* at 471. As another commentator noted, "Available evidence indicates that the physician's decisions to withhold information are based on hearsay rather than on actual experience with the effects of full disclosure and that the physician's own emotional reluctance to confront the patient with stark diagnoses and risks often prevents disclosure." Note, *Restructuring Informed Consent, supra* p. 14.

Although patients are usually upset by the disclosure of serious risks of medical treatment, Meisel writes, it is not clear that being upset necessarily interferes with one's ability to engage in rational decisionmaking. Meisel, *supra* p. 19, at 461. Professor Simpson of Northwestern University Law School concurs with Meisel, arguing that the traditional pessimism of courts over the ability of patients to make rational decisions about their medical treatment is based on "myth" and conjecture. Simpson, *Informed Consent: From Disclosure to Patient Participation in Medical Decisionmaking*, 76 N.U. L. Rev. 172, 178 (1981). "It appears that the possibility of adverse effects arising from disclosure has been overstated," asserts Simpson. Studies show that the large majority of patients do not refuse treatment after being informed about "relatively risky medical procedures," that they withstand surgery better than uninformed patients and that, on the average, informed patients "suffer equal or lower levels of anxiety" than patients who are not informed. *Id.* at 180.

In the abortion context, the psychological harm to the patient assertedly associated with disclosure of information about the fetus (*see Planned Parenthood League of Massa-*

chusetts v. *Bellotti*, 641 F.2d at 1021; *Planned Parenthood Association of Kansas City, Mo.* v. *Ashcroft*, 655 F.2d at 868; *Charles* v. *Carey*, 627 F.2d at 784) may be experienced far more severely after the procedure has been irrevocably performed if the patient later learns about the information withheld from her. For example, *Good Housekeeping* interviewed a woman who had had an abortion in college while thinking that the fetus was just a "clump of cells." "A year later at a friend's house someone was passing around pictures of fetuses in various stages of development. When I saw that a three-month-old 'clump of cells' had fingers and toes and was a tiny, perfectly-formed baby, I became really hysterical." Rockmore, *Are You Sorry You Had an Abortion?* Good Housekeeping, July 1977, at 120-21 (*quoting* Julie Engel); *see also id.* at 162-63 (*quoting* Georgia Denk). Common sense suggests that the very women who are most likely to be upset by disclosures before the abortion, and thus those most likely to be candidates for the therapeutic exception, are the ones most likely to experience psychological complications after the abortion upon learning the information withheld. Furthermore, they are precisely the women whose choice would most likely be different if fully informed, and thus those most likely to be deprived of a truly autonomous choice by the paternalistic decision not to disclose.

Surely it should be within the legislature's discretion to decide whether, in a particular context, the adoption of a therapeutic exception enhances or harms informed consent legislation based on the "patient autonomy" approach. The decision of the Akron City Council not to include such an exception in the Akron Ordinance must be regarded as embodying a position grounded in precedent, properly responsive to the particular circumstances of abortion, and supported by respectable opinion in the scholarly debate.

VI.

WELL-PUBLICIZED ABUSES BY ABORTION CLINIC PHYSICIANS AND COUNSELORS MAKE IT PARTICULARLY APPROPRIATE FOR LEGISLATURES TO PREFER THE "PATIENT AUTONOMY" TO THE "PHYSICIAN PATERNALISM" APPROACH IN APPLYING THE INFORMED CONSENT DOCTRINE TO ABORTIONS.

Whatever may be the merits of the debate over "physician paternalism" and "patient autonomy" as applied to medical treatment in general, there is substantial evidence to justify a legislative conclusion that in a significant number of abortions there is a lack of meaningful contact and a fundamental conflict of interest between the physician and the patient. In many cases the physician-patient relationship is so poor that it vitiates the benevolent assumptions underlying the "physician paternalism" approach.

> The evidence presented at trial showed that the decision to terminate a pregnancy was made not by the woman in conjunction with her physician, but by the woman and lay employees of the abortion clinic, the income of which is dependent upon the woman's choosing to have an abortion. The testimony disclosed that the doctors at Akron Center's clinic did little, if any, counseling before seeing the patient in the procedure room. Akron's ordinance simply takes into account these realities of the "physician-patient" relationship at an abortion clinic.

Akron, 651 F.2d at 1217 (Kennedy, J., concurring in part and dissenting in part).

In a decision affirmed in relevant part by this Court, a three-judge court pointed out the essential difference between the circumstances surrounding many abortions and the doctor-patient interaction typical of other medical treatment.

> Abortions are frequently obtained in a specialized clinic or hospital department where a woman is removed from familiar medical surroundings. Most frequently the abortion is not done by a woman's regular doctor. The procedures, perhaps routine for those performing them, will probably be totally unlike any other theretofore undergone by the patient. In addition, as the record in this case indicates, the woman may well be experiencing considerable emotional anxiety.
>
> Generally, the abortion decision is somewhat hurriedly arrived at and executed. It, in many cases, may be attended by a retiscence [sic] that works to close off ordinary avenues of information to the patient either from friends or from family members.
>
> The state under such circumstances might understandably wish to be certain that each woman be given the facts regarding her condition, her options, the abortion procedure to be performed, and the possible future consequences of the choice she makes.

Planned Parenthood Association v. *Fitzpatrick*, 401 F. Supp. 554, 587 (E.D. Penn. 1975), *aff'd in relevant part*, 428 U.S. 901 (1976). In 1980, 75% of all abortions were performed in clinics or offices in which 1000 or more abortions were performed annually. Henshaw, Forrest, Sullivan & Tietze, *Abortion Services In The United States, 1979 & 1980*, 14 Fam. Plan. Perspectives 1, 12, Table 6 (1982).

What sort of doctors must many of the women seeking abortion turn to? On November 12, 1978, the *Chicago Sun-Times* began reporting the results of a five month undercover investigation of Chicago abortion clinics it had conducted in cooperation with the Better Government Association. "Reporters and researchers worked in six clinics where more than half of the 60,000 abortions in Illinois clinics were performed last year, according to state records and BGA [Better Government Association] estimates." Zekman & Warrick, *The Abortion Profiteers: Making a killing in Michigan Av. Clinics*, Chicago Sunday

Sun-Times, Nov. 12, 1978, at 4, col. 1. They found extremely questionable attitudes and practices in four of the clinics, as well as in two counseling and referral agencies. Excerpts from the exposé demonstrate that a legislature might logically conclude that the decisions made by some abortion clinics concerning what information to disclose to their patients are motivated by a desire for profits rather than by a good faith judgment based on their patients' best interests.

> At the Chicago Loop Mediclinic, . . . an administrator told women answering phones: "We have to corral the patients. . . . Our fiscal year ends in September, so go the extra mile."
>
> For their extra efforts, clinic workers get $5 cash bonuses for each abortion they sell over the phone.
>
> At a referral service that operates three hot lines, undercover BGA investigator Julia Rockler was admonished for not selling hard enough while working as an employee there.

Id. at 4, col. 3.

> "We are in the business of selling abortions," McCullough scolded. "When you are talking to these people, it's important to use the positive approach. It's not 'Do you want a termination?' but 'When do you want a termination?' Put the question to them as a sure sale. Limit their choices."

Zekman & Warrick, *Soft voices, hard sells—twin swindles,* Chicago Sun-Times, Nov. 17, 1978, at 4, col. 3.

> "Counseling?" said a former hot-line worker. "There was none. What we were doing there is selling abortions. We got no training except in what not to say. How not to use words like 'fetus' or 'kill' that might scare the customers away. Don't mention complications."
>
> Within minutes of being hired at McCullough's hot line, Rockler was told to start "counseling." When

she asked for help in explaining the abortion procedure to a patient, she was told to sum it up like this:

"A tube about the size of a pencil is inserted into the uterus and the vacuum aspirator is turned on and removes all the liquid. There is no scraping or cutting. Now do you have any questions?"

If there were questions, counselors were left to their own devices to answer them. "But McCullough's policy," said a former worker, "was to tell people as little as possible."

At both hot lines, women intentionally are told what will sell them on abortion. When patients complained of the cost of abortions at the Sanders hot line, Trossman heard counselors remind callers of the cost of not having an abortion.

"Having a baby is a $410,000 question," a hot line caller was told. "Do you have that kind of money to raise a kid?"

Id. at 5, col. 2.

Often, as the series documented, the abortion-performing physician, far from counseling the patient, has no contact with her until she is in the procedure room.

A woman who had an abortion one early August morning recalls lying on the operating table waiting for her doctor—30-year-old Dr. Pankaj Thaker—to get to her. "I could swear there was only one doctor and he just went down the line giving abortions," said the woman.

. . .

"He didn't say a word. He came in and did it and walked out in three minutes. Then he started down the hall again. . ."

Zekman & Warrick, *The Abortion lottery: Women take chances with 'tryout' doctors,* Chicago Sun-Times, Nov. 14, 1978, at 4, cols. 1, 4.

In this hectic assembly-line, profit-hungry atmosphere, there is little time for or interest in genuine counseling by the staff, let alone the doctor.

> At the Biogenetics clinic, BGA investigator Michelle Young was ordered by her supervisor to stop counseling a distraught patient and get back to the reception desk.
>
> "We don't have time for [counseling]," the supervisor said. "We're much too busy."
>
> When staff members do have time to talk to patients, they are under orders not to say anything to scare the women away.
>
> "Don't tell them it hurts" our undercover counselor was told. "Don't answer too many questions because the patient gets too nervous, and the next thing you know they'll be out the door."

Zekman & Warrick, *Dr. Ming Kow Hah: physician of pain*, Chicago Sun-Times, Nov. 15, 1978, at 4, col. 4.

In the *Akron* case, a physician employed by one of the plaintiff clinics testified that the need for disclosure is limited because he assumes that an abortion clinic patient has "already made her own decisions. . . . When you go to a bar, you go there to drink." Tr. VII, 33-34. But the *Sun-Times* investigation provided evidence from which a legislature could properly conclude this is not always the case.

> Not all women who go to abortion clinics are sure they want abortions. Some arrive confused and frightened, not at all sure they want to be there.
>
> Some have been dragged into clinics by relatives; others pressured into abortion by husbands or boy friends.
>
> . . .
>
> [A] Biogenetics patient told The Sun-Times she might not have gone through with her abortion had someone taken the time to counsel her.

> "I wasn't counseled at all," she said. "The nurse just took my name down and filled out the application. She gave a quick explanation of the procedure, but that's not counseling. I wasn't sure I wanted an abortion. I really wanted to talk to somebody about it."

Zekman & Warrick, *Counseling the patient: Buy this abortion,* Chicago Sun-Times Nov. 24, 1978, at 5, cols. 1, 4.

In *Canterbury* v. *Spence,* 464 F.2d at 784, the District of Columbia Circuit said, "Respect for the patient's right of self-determination on particular therapy demands a standard set by law for physicians rather than one which physicians may or may not impose upon themselves." Surely the abuses documented make it constitutionally appropriate for a legislature, if it chooses, to enact laws establishing informed consent specifications for physicians engaged in abortion practice which depart from the "physician paternalism" assumption that doctors know best what degree of disclosure is right for their patients and can be trusted to act in their best interests.

VII.

THE CONSTITUTION SHOULD NOT BE INTERPRETED TO PRECLUDE RELIANCE ON THE "PATIENT AUTONOMY" APPROACH WHEN STATES ACT TO PROTECT THE RIGHT OF WOMEN TO GIVE INFORMED CONSENT TO ABORTION.

The constitutional liberty which encompasses abortion is "the freedom of a woman to decide whether to terminate a pregnancy." *Harris* v. *McRae,* 448 U.S. 297, 312 (1980). This "freedom of choice" (*id.*) includes "at least an equal right to choose to carry her fetus to term as to choose to abort it." *Maher* v. *Roe,* 432 U.S. at 472 n.7. Surely the legislature has a legitimate and compelling interest in

protecting the exercise of this fundamental constitutional right.

On the other hand, physicians have no constitutional right to a "physician paternalism" standard of disclosure; their protection from state interference is purely derivative from "the right of a pregnant woman to decide whether or not to bear a child." *Whalen* v. *Roe*, 429 U.S. 589, 604-605n.33 (1977). Physicians have no constitutional entitlement, therefore, to ensure that only a "physician paternalism" approach to informed consent is applied to abortion, while the legislature has the strongest constitutional warrant for applying the "patient autonomy" approach.

The Akron City Council has not "singled out" abortion for the application of the "patient autonomy" approach; the informed consent law of Ohio employs the "patient autonomy" approach, with no therapeutic exception, in dealing with all medical procedures. *See* this brief, *supra* at 12, 18. The Council has simply applied the general Ohio rule to the particular circumstances of abortion. A statute as precise as the Akron Ordinance in what it requires to be disclosed is not without precedent in the field of informed consent legislation. Some informed consent laws establish what physicians must disclose about particular operations with a similar degree of detail: Tex. Rev. Civ. Stat. Ann. art. 4590 § 6.05 (Vernon Supp. 1982), as implemented by 3 Tex. Reg. 4293 (1978), names, for example, five specific potential consequences of abdominal and vaginal hysterectomies to be communicated to the patient.

In light of the abuses related in Section V of this brief, however, even a jurisdiction that generally adheres to the "physician paternalism" approach, or accepts the therapeutic exception to the "patient autonomy" approach,

could properly decide that the special circumstances created by the socioeconomic context in which abortions are frequently performed suggest a need for the application of a "patient autonomy" approach, without any therapeutic exception, to protect women considering whether to terminate their pregnancies.

This Court pointed out in *Planned Parenthood of Central Missouri* v. *Danforth*, 428 U.S. 52, 67 (1976), that when a consent requirement "for any surgery" would be constitutional, there is "no constitutional defect in requiring it only for some types of surgery as . . . for abortions." If the "patient autonomy" approach is constitutional as applied to medical treatment in general, it should be equally constitutional as applied to abortion whether the jurisdiction generally applies it to all medical treatment, as Ohio does, or particularly to abortion because of the special circumstances surrounding that procedure.

CONCLUSION

Justice Holmes wrote in his famous "now vindicated dissent in *Lochner* v. *New York*, 198 U.S. 45, 76 (1905)", *Roe* v. *Wade*, 410 U.S. at 117:

> [A] constitution is not intended to embody a particular economic theory, whether of paternalism and the organic relation of the citizen to the State or of laissez faire. It is made for people of fundamentally different views, and the accident of our finding certain opinions natural and familiar or novel or even shocking ought not to conclude our judgment upon the question whether statutes embodying them conflict with the Constitution of the United States.

Despite the sustained debate among the States and eminent legal commentators over the conflicting socioeconomic theories underlying the competing informed consent models of "physician paternalism" and "patient autonomy," the lower federal courts have not hesitated to con-

clude that abortion related statutes embodying the "patient autonomy" model conflict with the Constitution of the United States. In their view, the Constitution enacts, if not Mr. Herbert Spenser's *Social Statics*, Sir William Osler's *Aequanimitas and Other Addresses* (1904) (the classic work on medical ethics which strongly advocates physician paternalism).

No matter how compelling may be that set of disquisitions on the augustly paternalistic role of the physician, however, it has no proper claim to decide forever informed consent policy for the nation in lieu of the more democratically responsive state and local legislatures.

Whatever standards this Court may enunciate to govern statutes designed to ensure informed consent to abortion, they should not be such as will freeze in constitutional concrete the "physician paternalism" approach, so as to ban forever and altogether continued experimentation and debate concerning the alternative approach which seeks to foster patient autonomy.

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APPENDIX: NOTES TO TABLE OF CURRENT POSITIONS ON THE APPROACH TO INFORMED CONSENT BY STATE

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[1] ALABAMA. *Roberts* v. *Wood*, 206 F.Supp. 579 (S.D. Ala. 1962).

[2] ALASKA. *Poulin* v. *Zoitman*, 542 P.2d 251 (Alaska 1975); *Patrick* v. *Sedwick*, 391 P.2d 453 (Alaska 1964); Alaska Stat. §09.55.556 (Supp. 1981). The common law standard of disclosure is not adequately articulated in these two cases. However, the statute requires that a physician disclose common risks and reasonable alternatives to the proposed treatment. The health care provider may limit the extent of the information disclosed if he reasonably believes that a full disclosure would have an adverse effect on the patient's condition.

[3] ARIZONA. *Shetter* v. *Rochelle*, 2 Ariz. App. 358, 409 P.2d 74 (Ct. App. 1965). Note, however, that even though Arizona follows a "physician paternalism" rule, the court said that the consenter must understand substantially the nature of the surgical procedure attempted and the probable results of the operation.

[4] ARKANSAS. *Regram* v. *Sisco*, 406 F.Supp. 776 (W.D. Ark. 1976).

[5] CALIFORNIA. *Cobbs* v. *Grant*, 8 Cal. 3d 229, 502 P.2d 1, 104 Cal. Rptr. 505 (1972); California applies the "patient autonomy" approach with respect to any potential of death or serious harm; beyond such risks, disclosure is required according to the "physician paternalism" rule.

[6] COLORADO. *Mallett* v. *Pirkey*, 171 Colo. 271, 466 P.2d 466 (1970). Though the rule in Colorado falls under a "physician paternalism" model, the burden rests upon the doctor to prove, if challenged, that his behavior conformed to acceptable standard physician practice.

[7] CONNECTICUT. To date, Connecticut has no law on informed consent.

[8] DELAWARE. *Coleman* v. *Garrison*, 349 A.2d 8 (Del. 1975); Del. Code Ann. tit. 18, §§6851-6852 (Supp. 1980).

[9] DISTRICT OF COLUMBIA. *Canterbury* v. *Spence*, 464 F.2d 772 (D.C. Cir.), *cert. denied*, 409 U.S. 1064 (1972).

[10] FLORIDA. *Ditlow* v. *Kaplan*, 181 So.2d 226 (Fla. Dist. Ct. App. 1965); *Bowers* v. *Talmadge*, 159 So. 2d 888 (Fla. Dist. Ct. App. 1964); Fla. Stat. Ann. §768.46 (West Supp. 1982). Under the Florida statute, a physician may disclose information in accordance with accepted medical practice, but that degree of disclosure must be sufficient to permit a reasonable individual to have a general understanding of the procedure, acceptable alternative treatments, and any substantial risks and hazards recognized as inherent in the procedure. *Accord Bowers* v. *Talmadge*, but *Ditlow* v. *Kaplan* holds that a doctor who advises a patient that a procedure is serious and "risky" should be discharged unless the plaintiff presents expert testimony that it is the custom to volunteer more detailed information.

[11] GEORGIA. *Young* v. *Yarn*, 136 Ga. App. 737, 222 S.E.2d 113 (Ct. App. 1975); Ga. Code Ann. §§88-2901 to -2907 (1979). Not applicable to abortion and sterilization.

[12] HAWAII. *Nishi* v. *Hartwell*, 52 Hawaii 188, 473 P.2d 116 (1970); Hawaii Rev. Stat. §§671-73 (1976). The statute fails to specify the standard by which the adequacy of the physician's disclosure is to be measured. The statute empowers the state board of medical examiners to establish these standards. Under *Nishi*, a "physician paternalism" rule was adopted, but that standard could be superceded by the medical board requirements.

[13] IDAHO. *LePlelly* v. *Grefenson*, 101 Idaho 422, 614 P.2d 762 (1980); Idaho Code §18-609 (Supp. 1982), §§39-4301 to -4306 (1977). Under *LePlelley*, though the "physician paternalism" rule is adopted, the court held that when relatively complicated surgery is involved a physician must disclose known risks of death or serious bodily injury. Although §§39-4301 to -4306 adopt a "physician paternalism" approach, they do not apply to abortion procedures. A "patient autonomy" approach to abortion is provided in §18-609.

[14] ILLINOIS. *Green* v. *Hussey*, 127 Ill. App. 2d 174, 263 N.E. 2d 156 (App. Ct. 1970); Ill. Rev. Stat. ch. 38, §81-23.2 (1981). Though *Green* adopts the "physician paternalism" rule, Illinois statutory law adopts the "patient autonomy" approach for abortion procedures.

[15] INDIANA. *Joy* v. *Chau*, 377 N.E.2d 670 (Ind. Ct. App. 1978). The *Joy* court held that a physician is to make a reasonable disclosure to his patient, but failed to adopt either of the two rules.

[16] IOWA. *Grosjean* v. *Spencer*, 258 Iowa 685, 140 N.W. 2d 139 (1966); Iowa Code Ann. §147.137 (West Supp. 1982-83). Prior to the adoption of the statute, Iowa followed the "physician paternalism" rule. Though the statute cannot be classified as following either of the two rules, it does require the physician to disclose the nature and purpose of the proposed treatment and the known risks if they are included in a specified list of serious dangers.

[17] KANSAS. *Natanson* v. *Kline*, 186 Kan. 393, 350 P.2d 1093 (1960).

[18] KENTUCKY. *Holton* v. *Pfingst*, 534 S.W.2d 786 (Ky. 1975); *Bennett* v. *Graves*, 357 S.W.2d 893 (Ky. Ct. App. 1977); Ky. Rev. Stat. Ann. §§304.40-320 (Baldwin 1981). *Bennett* and *Holton* adopt the "physician paternalism" rule. However, the statutory provisions adopted after *Holton* require that information be provided to the patient such that "a reasonable individual . . . would have a general understanding of the procedure and . . . acceptable alternative procedures . . . and substantial risks and hazards inherent in the proposed treatment. . . ."

[19] LOUISIANA. *Percle* v. *St. Paul Fire and Marine Ins. Co.*, 349 So.2d 1289 (La. Ct. App. 1977); La. Rev. Stat. Ann. §40:1299.40 (West. 1977).

[20] MAINE. *Woolley* v. *Henderson*, 418 A.2d 1123 (Me. 1980); Me. Rev. Stat. Ann. tit. 24, §2905 (Supp. 1981-1982).

[21] MARYLAND. *Sard* v. *Hardy*, 281 Md. 432, 379 A.2d 1014 (Ct. App. 1977).

[22] MASSACHUSETTS. *Schroeder* v. *Lawrence*, 372 Mass. 1, 359 N.E.2d 1301 (1977); *Haggerty* v. *McCarthy*, 344 Mass. 136, 181 N.E.2d 562 (1962). It appears that Massachusetts follows the "physician paternalism" standard. However, the cases do not expressly address the standard for disclosure. Though *Haggerty* refers to the "physician paternalism" standard, the more recent *Schroeder* case cited *Canterbury* v. *Spence* and appeared to commend its reasoning.

[23] MICHIGAN. *Roberts* v. *Young*, 369 Mich. 133, 119 N.W.2d 627 (1963).

[24] MINNESOTA. *Plutshack* v. *University of Minn. Hospitals*, 316 N.W.2d 1 (Minn. 1982); *Cornfeldt* v. *Tongren*, 262 N.W. 2d 684 (Minn. 1977); Minn. Stat. Ann. §144.651 (West Supp. 1982).

[25] MISSISSIPPI. *Ross* v. *Hodges*, 234 So.2d 905 (Miss. 1970).

[26] MISSOURI. *Aiken* v. *Carey*, 396 S.W.2d 668 (Mo. 1965).

[27] MONTANA. *Negaard* v. *Estate of Feda*, 152 Mont. 47, 446 P.2d 436 (1968).

[28] NEBRASKA. No case law. Neb. Rev. Stat. §44-2816 (1978).

[29] NEVADA. *Corn* v. *French*, 71 Nev. 280, 289 P.2d 173 (1955); Nev. Rev. Stat. §41A.110 -.120 (1981). Under the Nevada statute, neither the "physician paternalism" nor "patient autonomy" rules are adopted. Instead the statute delineates information that must be provided for patient consent. These include the general nature of the procedure to be undertaken, its risks, and any alternative treatments feasible. To that extent, the statute follows the "patient autonomy" rule.

[30] NEW HAMPSHIRE. *Folger* v. *Corbett*, 118 N.H. 737, 394 A.2d 63 (1978); N.H. Rev. Stat. Ann. §507-C (Supp. 1981). Declared void by Supreme Court of New Hampshire in *Carson* v. *Maurer*, 120 N.H. 925, 424 A.2d 825 (1980).

[31] NEW JERSEY. *Kaplan* v. *Haines*, 96 N.J. Super. 242, 232 A.2d 840 (1967), *aff'd* 51 N.J. 404, 241 A.2d 235 (1968).

[32] NEW MEXICO. *Henning* v. *Parsons*, 95 N.M. 454, 623 P.2d 574 (1981).

[33] NEW YORK. *Karlsons* v. *Guerinot*, 57 A.D.2d 73, 394 N.Y.S.2d 933 (App.Div. 1977); N.Y. Public Health Law §2805-d (McKinney Supp. 1982).

[34] NORTH CAROLINA. *Butler* v. *Berkeley*, 25 N.C. App. 325, 213 S.E.2d 571 (Ct. App. 1975); N.C. Gen. Stat. §90-21.13 (1981). Under the statute, a disclosure consistent with general medical practice is sufficient only if such disclosure gives the patient a general understanding of the treatment and its recognized risks.

[35] NORTH DAKOTA. *Walker* v. *North Dakota Eye Clinic*, 415 F.Supp. 891 (D.N.D. 1976); N.D. Cent. Code §26-40.1-04 to -05 (1978). Statute declared unconstitutional in *Arneson* v. *Olsen*, 270 N.W.2d 125 (N.D. 1978).

[36] OHIO. *Congrove* v. *Holmes*, 37 Ohio Misc. 95, 308 N.E.2d 765 (Comm. Pleas 1973); Ohio Rev. Code Ann. §2317.54(A) (Baldwin Supp. 1981).

[37] OKLAHOMA. *Lambert* v. *Park*, 597 F.2d 236 (10th Cir. 1979); *Martin* v. *Stratton*, 515 P.2d 1366 (Okla. 1973). The *Martin* court failed to adopt either of the two rules. In *Lambert*, however, the Tenth Circuit adopted the "patient autonomy" rule for Oklahoma. After discussing several reasons for adopting the "patient autonomy" approach the court said:

> We have chosen between the tests only because the Oklahoma Court has indicated it would do so. The Court need not, however, consider itself so limited. The better practice would be to adopt a rule allowing for the application of whichever test best comports with the theories of the parties and the evidence produced during the trial.

Lambert v. *Park*, 597 F.2d at 299.

[38] OREGON. *Holland* v. *Sisters of St. Joseph of Peace*, 270 Or. 129, 522 P.2d 208 (1974); Or. Rev. Stat. §677.097 (1981).

[39] PENNSYLVANIA. *Jeffries* v. *McCague*, 242 Pa. Super. 76, 363 A.2d 1167 (Super. Ct. 1976); *Cooper* v. *Roberts*, 220 Pa. Super. 260, 286 A.2d 647 (1971); Pa. Stat. Ann. tit. 40, §1301.103 (Purdon Supp. 1982).

[40] PUERTO RICO. *Torres Perez* v. *Hospital Doctor Susoni*, 95 P.R.R. 845 (1968).

[41] RHODE ISLAND. *Wilkinson* v. *Vesey*, 110 R.I. 606, 295 A.2d 676 (1972), R.I. Gen. Laws §9-19-32 (Supp. 1981).

[42] SOUTH CAROLINA. *Walker* v. *Pierce*, 560 F.2d 609 (4th Cir. 1977). To date, no standard has been enunciated in South Carolina.

[43] SOUTH DAKOTA. *Cunningham* v. *Yankton Clinic*, 262 N.W.2d 508 (S.D. 1978). To date, no standard has been enunciated in South Dakota.

[44] TENNESSEE. *Longmire* v. *Hoey*, 512 S.W.2d 307 (Tenn. Ct. App. 1974); Tenn. Code Ann. §29-26-118 (1980).

[45] TEXAS. *Karp* v. *Cooley*, 493 F.2d 408 (5th Cir. 1974); *Wilson* v. *Scott*, 412 S.W.2d 299 (Tex. 1967); Tex. Rev. Civ. Stat. Ann. art. 4590; §§6.03-.07 (Vernon Supp. 1982), implemented by 3 Tex. Reg. 4293 (1978). Though *Wilson* makes it clear that the "physician paternalism" approach applies, under the statute a state board promulgates rules that govern the degree of disclosure necessary for certain types of medical procedures.

[46] UTAH. *Ficklin* v. *McFarlane*, 550 P.2d 1295 (Utah 1976); Utah Code Ann. §78-14-5 (1977).

[47] VERMONT. *Small* v. *Gifford Memorial Hospital*, 133 Vt. 552, 349 A.2d 703 (1975); Vt. Stat. Ann. tit. 12, §1909 (Supp. 1981). Under *Small*, the Vermont Supreme Court adopted the "patient autonomy" approach. The statute, however, though prescribing the elements of information that must be disclosed—i.e. the alternatives to the treatment or diagnosis and the risks and benefits involved—incorporates these requirements in a "physician paternalism" approach.

[48] VIRGINIA. *Bly* v. *Rhonds*, 216 Va. 645, 222 S.E.2d 783 (1976).

[49] WASHINGTON. *Miller* v. *Kennedy*, 11 Wash. App. 272, 522 P.2d 852 (Ct. App. 1974), *aff'd*. 85 Wash. 2d 151, 530 P.2d 334 (1975); Wash. Rev. Code Ann. §§7.70.050-.060 (Pocket Part 1982).

[50] WEST VIRGINIA. No law.

[51] WISCONSIN. *Trogun* v. *Fruchtman*, 58 Wis.2d 569, 207 N.W.2d 297 (1973).

[52] WYOMING. *Govin* v. *Hunter*, 374 P.2d 421 (Wyo. 1962).